

# **EXHIBIT “A”**

## **Part 1**

IN THE UNITED STATES DISTRICT COURT FOR THE  
WESTERN DISTRICT OF PENNSYLVANIA

TINA LINDQUIST,

Plaintiff,

-vs-

HEIM, L.P.,

Defendant.

Civil Action  
No. 04-249E

**CERTIFIED TRANSCRIPT**

VIDEO DEPOSITION OF: John Hood, M.D.

DATE: February 23, 2007  
Friday, 2:00 p.m.

LOCATION: 300 State Street  
Erie, PA

TAKEN BY: Plaintiff  
Tina Lindquist

REPORTED BY: Cynthia A. Hawley  
Notary Public  
AKF Reference No. CH98501

1 VIDEO DEPOSITION OF JOHN HOOD, M.D.,  
2 a witness, called by the Plaintiff, Tina Lindquist,  
3 for examination, in accordance with the Federal Rules  
4 of Civil Procedure, taken by and before Cynthia A.  
5 Hawley, a Court Reporter and Notary Public in and for  
6 the Commonwealth of Pennsylvania, at the offices of  
7 Hand Microsurgery, 300 State Street, Suite 205, Erie,  
8 Pennsylvania, on Friday, February 23, 2007,  
9 commencing at 2:07 p.m.

10 - - - -

11 APPEARANCES:

12 FOR THE PLAINTIFF, TINA LINDQUIST:  
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ALSO PRESENT:  
Ronald J. Stephens, videographer

1 \* I N D E X \*

2	Examination by Mr. Conlin - - - - -	4
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10 \* I N D E X \* OF E X H I B I T S \*

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16 (Exhibits were retained by Mr. Conlin.)

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1 MR. CONLIN: Before we begin with the  
2 doctor's deposition, counsel and I have agreed  
3 that at the time of the trial of this matter  
4 the defendants are going to stipulate to the  
5 amount of medical bills paid by the worker's  
6 compensation carrier without the need for  
7 further testimony from Dr. Hood or anybody from  
8 his staff in the billing department.

9 I had forwarded a stipulation to  
10 Attorney Robinson back on December 6th of 2006  
11 and at that time the amount of bills that  
12 worker's compensation had paid was \$199,739.57.  
13 I have reason to believe that that number has  
14 increased and it will certainly increase by the  
15 time this matter proceeds to trial.

16 I just want to make sure that we have  
17 that understanding with defense counsel that  
18 that figure can go in without further testimony  
19 from the physician.

20 MR. SCOULOS: Yes, we have that  
21 agreement. And it's our intention to formalize  
22 the agreement via stipulation. And we realize  
23 if for some reason we can't hammer out a  
24 stipulation you have the right to recall  
25 Dr. Hood or anyone else for that matter to

1 prove your case.

2 On the subject of agreements in  
3 today's deposition, it's my understanding that  
4 you might, but you are not sure if you will,  
5 have the doctor review and identify photographs  
6 of his patient. So we do not clutter up the  
7 record, I will pose my objections to certain of  
8 the photographs at this time with the  
9 understanding that I have a standing objection  
10 if you do choose to display them today.

11 In particular, I have objections to  
12 photos 69 through 80. Those are the numbers  
13 that have been used throughout the proceedings.  
14 69 through 80 inclusive. The basis for the  
15 objection is that those photographs are highly  
16 prejudicial and the prejudicial effect  
17 outweighs their relevancy and their utility in  
18 having the doctor explain what he was facing  
19 throughout the course of his treatment. Do you  
20 agree?

21 MR. CONLIN: I disagree with the  
22 reason, but you certainly have the objection.

23 MR. SCOULOS: You agree to standing  
24 objection?

25 MR. CONLIN: I agree it's a standing

1 objection. You do not need to interrupt me.  
2 And just so there's no misunderstanding, I will  
3 be using photographs. I simply don't know if  
4 I'll be using all the ones you find  
5 erroneously objectionable.

6 MR. SCOULOS: Yes. Understood.  
7 Thank you.

8 THE VIDEOGRAPHER: Today is Friday  
9 February 23, 2007. The time is approximately  
10 2:07 p.m. The location is 300 State Street,  
11 Erie, Pennsylvania. My name is Ronald J.  
12 Stephens, video specialist. This is case No.  
13 04-249E, entitled Tina Lindquist, plaintiff,  
14 versus Heim, L.P., defendant.

15 The deponent is Dr. John M. Hood,  
16 M.D. This deposition is requested by the  
17 plaintiff. Counsel and everyone here will  
18 please identify themselves for the record.

19 MR. CONLIN: Ray Conlin on behalf of  
20 the plaintiff.

21 MR. SCOULOS: Gary Scoulos on behalf  
22 of Heim, Incorporated.

23 THE VIDEOGRAPHER: The deponent may  
24 now be administered the oath by Cindy Hawley of  
25 AKF Court Reporting.

1 -----

2 JOHN HOOD, M.D.,  
3 being first duly sworn,  
4 was examined and testified as follows:

5 - - - -

6 EXAMINATION

7 - - - -

8 BY MR. CONLIN:

9 Q. Good afternoon, doctor. As I stated earlier my  
10 name is Ray Conlin. I'm here on behalf of Tina  
11 Lindquist. Would you please state your name  
12 for the members of our jury?

13 A. Yes. My name is John Michael Hood. I am a  
14 orthopedic physician who has training in hand  
15 surgery and microsurgery.

16 Q. Where do you maintain your principle office,  
17 doctor?

18 A. 300 State Street, Suite 205 in Erie,  
19 Pennsylvania.

20 Q. So just a few blocks from the Federal  
21 Courthouse?

22 A. That's correct.

23 Q. Can you tell us a little bit about your  
24 education, doctor? Where did you attend  
25 college?



1 A. I went to Gannon University here in Erie,  
2 Pennsylvania. I was part of the Gannon  
3 Hahnemann program, which I went to  
4 undergraduate for two years. Basically put  
5 three and a half years training in a two-year  
6 time frame. Then went directly on to medical  
7 school at Hahnemann University in Philadelphia.

8 There I detriculated after four years  
9 and got my M.D. From there I went to Hamot  
10 Medical Center in Erie, Pennsylvania for a  
11 five-year residency in orthopaedics. Following  
12 that residency I went back to Philadelphia to  
13 the University of Pennsylvania for a one-year  
14 fellowship in hand and upper extremity surgery.

15 Q. Can you explain for me, doctor, what is a  
16 fellowship? What's the meaning of that word?

17 A. Well, a fellowship is, it's almost like being a  
18 journeyman. Okay. I am already a qualified  
19 orthopedic surgeon, but I wanted extra special  
20 training in a certain subset of orthopedics, in  
21 this case hand upper extremity and  
22 microsurgery.

23 So it was a year working with three  
24 hand surgeons in the Philadelphia area,  
25 University Hospital, Children's Hospital,

1 Philadelphia Yaden Hospital. And over in  
2 Cherry Hill. There was a couple offices I went  
3 to as well in New Jersey. But the whole year  
4 was devoted into learning and dealing with  
5 disorders of the upper extremity.

6 Q. Okay. Doctor, did you ever obtain any type of  
7 board certification in your specialty?

8 A. Yes. I am certified in orthopaedics. And I've  
9 passed the certificate of additional  
10 qualification for hand surgery.

11 Q. Can you explain for us the significance in the  
12 process of becoming board certified first  
13 generally in orthopedic surgery and then in the  
14 subspecialty?

15 A. Well, it means that the governing body in  
16 orthopedics has decided that by passing the  
17 examinations, both the written and oral  
18 examinations in orthopedics, that I am  
19 qualified to practice and proceed with the  
20 responsibilities of an orthopaedic surgeon in  
21 this country.

22 The certificate of additional  
23 qualification is a specialty examination that  
24 one can take after taking a year long  
25 fellowship. And in passing that examination I

1 have made the qualification for the American  
2 Society for Surgery of the Hand and able to  
3 officially say that I'm a hand surgeon.

4 Q. Okay. Doctor, are you currently involved in  
5 the instruction of any medical students or  
6 residents?

7 A. Yes, I am.

8 Q. Can you tell me just briefly about that?

9 A. At Hamot, where I actually had my orthopedic  
10 residency, we still have a residency program.  
11 I teach residents from Hamot Medical Center. I  
12 teach residents from Millcreek Community  
13 Hospital in their orthopedic program. I teach  
14 residents at Shriner's Hospital for Crippled  
15 Children in pediatric orthopedics to Hamot  
16 residents, University of Pittsburgh and  
17 residents from the Michigan area. I don't  
18 remember which hospital it is, but residents  
19 that follow through there.

20 Q. And in your practice are you also called upon  
21 from time to time to give lectures and seminars  
22 to other surgeons about your subspecialty of  
23 hand surgery?

24 A. Yes, I am.

25 Q. How long have you been licensed to practice

1 medicine in the Commonwealth of Pennsylvania?

2 A. Since 1990, since 1990.

3 Q. In addition to the lectures --

4 A. I believe it was 1990. Sorry. It's been so  
5 long I'm forgetting.

6 Q. In addition to the lectures and seminars that  
7 you do for other physicians have you ever been  
8 called upon to write any articles or present  
9 any exhibits relative to your subspecialty of  
10 hand surgery?

11 A. Yes, I have.

12 MR. CONLIN: At this time I would  
13 offer Dr. Hood as an expert witness in the  
14 specialty of orthopedic surgery of the hand and  
15 upper extremity and ask counsel if they have  
16 any questions on qualifications.

17 MR. SCOULOS: We have no objection to  
18 the doctor's participation, nor do we have any  
19 questions. Thank you.

20 MR. CONLIN: Thank you.

21 BY MR. CONLIN:

22 Q. Doctor, have you been Tina Lindquist's treating  
23 hand surgeon since September 25th of 2002?

24 A. Yes, I have.

25 Q. Can you explain to the members of the jury how

1 it was that you first met Tina?

2 A. I was called to the emergency room, um, on that  
3 day. Tina apparently had been in an industrial  
4 accident at her place of employment, Corry  
5 Manufacturing Company I believe it was. She  
6 apparently had a press close down on both of  
7 her hands. And she had very severe injuries to  
8 both hands.

9 Q. When you say very severe injuries, did you  
10 record your observations of how Tina appeared  
11 the very first time you saw her with respect to  
12 her hands?

13 A. Yeah. She basically had a crushing injury and  
14 evulsions. So her fingers were pressed to  
15 about the thickness of a quarter between -- and  
16 I'll show you here -- between this level here,  
17 which is the, we call this the distal ulnar  
18 crease. So that crease right through there up  
19 until this area. So this area from here to  
20 here was completely crushed and evulsed.

21 She had torn all the blood vessels to  
22 all four of the fingers apart on both hands.  
23 She had mashed the tendons that allow you to  
24 bend and extend the fingers, but they were  
25 basically intact. And the bones and the joints

1           were completely destroyed in this zone from  
2           about here across there of the hand.

3                       So these knuckles back through here  
4           were gone. And for the small finger, most of  
5           this finger was crushed in both hands and  
6           crushed up to about this level. So the tips  
7           were all right but the rest of the fingers were  
8           completely demolished.

9   Q.   And you say that they were crushed down flat  
10       almost to the width of a quarter?

11   A.   Yes.

12   Q.   So if you hold your hand sideways it would have  
13       been that thin?

14   A.   Yes.

15   Q.   And that would have been true for both her  
16       right hand and her left hand?

17   A.   Yes, sir.

18   Q.   Now, is there a name for that? What is the  
19       original diagnosis that you gave to that  
20       injury?

21   A.   Basically it's a crush evulsion injury of her  
22       hands, of her fingers, index, long, middle and  
23       small finger, ring and small fingers of both  
24       hands.

25   Q.   And in your years of orthopedic surgery had you

1 encountered somebody who had the type of crush  
2 evulsion injury?

3 A. Yes.

4 Q. Did you develop a battle plan and course of  
5 action about how you were going to attempt to  
6 treat this problem?

7 A. Yes.

8 Q. Can you explain for me what the initial  
9 treatment was that you gave to Tina?

10 A. Well, you know, initially she was stabilized in  
11 the emergency room, given fluids, given some  
12 pain medicine. We called immediately for the  
13 operating room and said that we needed to  
14 operate in teams in the operating room because  
15 we needed to work on both hands at the same  
16 time.

17 This type of surgery often will last  
18 12, 14 hours when trying to revascularize and  
19 repair and reconstruct these severe crushing  
20 injuries and evulsion injuries. You need to  
21 reestablish blood flow. You need to  
22 reestablish bony continuity. You need to  
23 reestablish skin, so coverage of those  
24 underlying soft tissues. And you need to  
25 reestablish nerve supply so that eventually

1           there is some feeling to these fingers.

2                       In the operating room with her, two  
3           surgeons took care of her. I took care of her  
4           right hand. Dr. Williams, one of my other hand  
5           surgery associates, took care of her left hand.  
6           We had two operating microscopes in the room.

7                       And the initial inspection of the  
8           wounds under the microscope showed that the  
9           small fingers were unsalvageable because the  
10          crushing was so far out that trying to place  
11          those back on would have left a, really just a  
12          nonviable knubbing or very small piece, maybe  
13          something like that on the end. And being down  
14          there it wouldn't have made much difference.

15                      We found once exploring the  
16          neurovascular bundles that the index fingers,  
17          um, were I believe more poor on the left side.  
18          So of the fingers that were remaining on the  
19          left hand, the middle finger and the ring  
20          finger were successfully revascularized,  
21          meaning to put the blood supply back into the  
22          fingers.

23                      That includes repairing arteries so  
24          that there's flow of blood into the fingers,  
25          and veins so that there is flow out of the



1 fingers. The skeleton was fixed with something  
2 called K wires. They're very thin wires that  
3 are about 10, 12 inches long that have sharp  
4 points on the end. They're about the thickness  
5 of a paper clip and diameter of the wire itself  
6 to give us temporary fixation so we can focus  
7 on doing the vascularized portion of this.

8 On her right hand I was able to  
9 successfully, at least initially, get the  
10 index, long and ring finger to be  
11 revascularized, and we pinned those as well.  
12 So we had several blood vessels to fix.

13 There is a time frame with that. Um,  
14 warm ischemia, meaning the fingers being at  
15 room temperature, we really only have about  
16 eight hours of time to reconnect the blood  
17 supply before the damage is so bad that there  
18 is no hope of them staying.

19 Cold ischemia we're able to keep them  
20 cold. If it was like it is outside today,  
21 let's say, and she was stuck outside for  
22 several hours she might have a 24-hour time  
23 frame to do it.

24 Q. But given the fact it happened in a warmer --

25 A. September, right.

1 Q. So you have to basically race against the clock  
2 to revascularize these fingers?

3 A. Yes.

4 Q. And you said you had to connect the arteries  
5 and the veins to take the blood into and out of  
6 the fingers?

7 A. Yes, sir.

8 Q. Are there -- how large are the arteries and  
9 veins in the finger? How do you do that?

10 A. Um, about a 32nd of an inch in diameter. We do  
11 it under a microscope. We have special tools  
12 that are very similar to a watchmaker's tools.  
13 They are very fine forceps and needle holders  
14 that we work under the microscope anywhere from  
15 4 to 20 magnification to clean up and bring  
16 these vessels together. And I use thread  
17 that's thinner than a human hair to suture  
18 these blood vessels back together.

19 Q. If I understand you correctly, doctor, are you  
20 actually stitching the two damaged ends of the  
21 blood vessels together with a thread finer than  
22 a human hair?

23 A. That's correct.

24 Q. And you're doing that with the use of a  
25 microscope?

1 A. That is correct.

2 Q. When you said there were two surgical teams,  
3 can you tell me how many people would have been  
4 there during that first operation?

5 A. Oh, dear.

6 Q. Two surgeons.

7 A. Two surgeons. Probably three or four  
8 circulators. Two scrubs that are actually, you  
9 know, assisting us directly. There was  
10 probably one or two residents in there as well.

11 Q. Anesthesiologist?

12 A. Anesthesiologist, probably a nurse anesthetist  
13 as well as a nurse anesthetist student.

14 Q. During that initial surgery -- that procedure  
15 is done under general anesthesia?

16 A. Yes.

17 Q. Did she require any type of blood transfusions  
18 or additional care like that?

19 A. I don't recall. That's pretty much taken care  
20 of by the anesthesiologist while we're focused  
21 on trying to revascularize the tissue.

22 Q. Okay. Now, after that is she transferred to  
23 post-op?

24 A. Yes.

25 Q. Can you tell me how she was after that first

1 surgery?

2 A. Well, we had her fairly well, for lack of a  
3 better term, doped up. What we try to do after  
4 surgery with these types of injuries is to  
5 prevent them from making adrenaline. All  
6 right. Now, pain can give you adrenaline.  
7 Being anxious will make more adrenaline. Doing  
8 depositions will make you produce adrenaline.  
9 So all those types of things can increase that.

10 And what adrenaline does is that it  
11 constricts the blood vessels. It makes them  
12 smaller so that the flow of blood going through  
13 them is less and less, and if it gets small  
14 enough it will clot off the blood vessel and  
15 then the finger dies.

16 So we had her on medications, such as  
17 Thorazine, which used to be a long time ago  
18 used as an antipsychotic medication, but in  
19 lower doses it has two effects. One, it has a  
20 calming effect so that they tend not to care  
21 what's going on. And two, it has a  
22 vasodilatory effect, meaning it makes the blood  
23 vessels kind of relax and get bigger.

24 We also, we have had her on some sort  
25 of a anticoagulant, Heparin, intravenously

1 initially, pain medicine either through a  
2 constant intravenous infusion or intermittent  
3 injections.

4 Her room would have been very warm.  
5 We usually try to keep the room above 78 to 82  
6 degrees. The whole idea there is to make the  
7 body think that it's very hot out. And when  
8 things are very hot the blood vessels in the  
9 arms and legs dilate more so they get larger,  
10 and also try to help the blood flow into and  
11 out of the fingers.

12 And she gets a lot of fluids. We try  
13 to dilute the blood so that there aren't  
14 necessarily as many platelets or red blood  
15 cells going through the area. So it's like  
16 thinning the fluid so that it's not as viscous,  
17 so that it flows more freely.

18 Q. Did Tina remain stable during that process  
19 post-op?

20 A. Yes, she did.

21 Q. Did you follow with her on a daily basis?

22 A. Yes. Twice daily initially.

23 Q. Was she an in-patient for that period of time?

24 A. Yes, she was.

25 Q. How long would she have remained an in-patient

1 following that first surgery?

2 A. Oh, boy. At least a week. It may have been  
3 two weeks. I would not have let anybody after  
4 a replantation leave before a week.

5 Q. Okay. Now, at that point in time did you  
6 anticipate there would be any complications  
7 from the injuries she sustained back on  
8 September 25th of 2002?

9 A. As far as anticipate, I would say yes because,  
10 I mean, for a severe crushing injury it's  
11 always a balance between how much tissue do you  
12 remove to ensure that you have what's left  
13 that's viable and how much do you try to save  
14 so that you can try to improve function.

15 So there's a balance there. And  
16 obviously there is a zone of injury. There's a  
17 zone where if you looked under a microscope  
18 that a pathologist would look at that he would  
19 say this is normal tissue. Then you get to a  
20 part where he says, oh, there's hemorrhage in  
21 the tissue, there's damage, there's crushing  
22 nature going on through here.

23 And then you go to the other end  
24 where it says, oh, this is normal tissue again.  
25 Well, ideally if you get your finger cut off

1 with a sharp knife the zone of injury is very  
2 narrow. So I can save the vast majority of the  
3 structures. Versus an injury which is  
4 basically just a crushing nature like being hit  
5 with a sledge hammer and the width of the  
6 damage is the width of the sledge hammer.

7 So that amount of tissue in this  
8 instance was severely damaged so we had to take  
9 a lot out. Um, we, I almost always expect with  
10 these types of injuries one or two other  
11 operations that are related to either tissues  
12 dying, infection, the hardware not holding,  
13 vascular problems where the blood vessels clot  
14 off and we have to go back in and free up the  
15 blood vessels, take the little clot out and  
16 then sew them back together again.

17 Q. So after the first surgery, if I'm correct,  
18 Tina's thumbs would have been intact on each  
19 hand; is that correct?

20 A. That's correct. There are no injuries to her  
21 thumbs.

22 Q. And her ring and long finger would have been  
23 intact on each hand?

24 A. Yes.

25 Q. Doctor, I'm going to show you a series of five

1           photographs and ask if you can identify those  
2           for us?

3       A.     Yeah. These are Tina's hands probably close to  
4           a month out after the surgery I would say from  
5           my recollection.

6       Q.     Is that how her hands would have appeared after  
7           the surgery, after that 10 to 12-hour procedure  
8           that you just described?

9       A.     The black areas would not have been there.  
10          Okay. The hands would have been much more  
11          swollen than what they are here.

12      Q.     Okay.

13      A.     And they would have been rather bloody.

14      Q.     Okay. Is that how her hands appeared though  
15          through the course of her post-op?

16      A.     Yes.

17      Q.     Okay.

18      A.     Yes.

19      Q.     Can you turn that around so the jury can see  
20          those?

21      A.     (Witness complies).

22      Q.     Thank you.

23                   MR. CONLIN: Just for the record, I'm  
24           going to have the court reporter mark that as  
25           Hood Deposition Exhibit 1, and it's photographs



1           70, 79, 80, 75 and 77.

2                               - - - -

3           (Exhibit No. 1 marked for identification.)

4                               - - - -

5       BY MR. CONLIN:

6       Q.     Doctor, after that initial surgery and post-op  
7               stay did Tina develop complications?

8       A.     Some of the skin necrosed.

9       Q.     What does that mean?

10      A.     That means some of the skin died.

11      Q.     Was an additional surgery necessary?

12      A.     Yes.

13      Q.     When did you do your next surgery on Tina?

14      A.     Let's look here. Sometimes the electronic  
15               system is not as good as the paper system, so  
16               excuse me for being a little slow here. Let's  
17               see.

18      Q.     Doctor, according to the records I've seen I  
19               believe the procedure was on October 5th of  
20               2002.

21      A.     Yes.

22      Q.     If that helps you find it on your computer.

23      A.     With almost 400 pages of documents in here it  
24               gets a little lengthy. Let's see here. What  
25               was that date, 10/5 you said?

1 Q. 10/5 of '02.

2 A. Okay. Yes. Okay. I've got it.

3 Q. Can you tell us, is that the time that she  
4 developed the complications with the skin on  
5 her hands dying?

6 A. Well, over the time from the date of her  
7 initial procedure and the injury until then,  
8 yes, that's when I felt that things had, we  
9 call it declaring where the tissues have pretty  
10 much shown me to a significant extent that this  
11 is definitely not going to make it, the tissue  
12 definitely is going to make it and the zone of  
13 indecision is somewhat smaller.

14 Q. What type of procedure was done on October 5th?

15 A. We did a called an irrigation and debridement.  
16 So the margins of the tissue that weren't  
17 healthy of the left hand were debrided down to  
18 healthy appearing tissue and we did a dressing  
19 change. On the right hand we did an amputation  
20 of the right index finger because that finger  
21 had obviously died and did a dressing change  
22 and once again some debridement of the long and  
23 ring finger tissues around that zone of the  
24 hand.

25 Q. By debridement, does that mean you are cutting

1 back the dead tissue?

2 A. Yes.

3 Q. Are these procedures, the debridements and the  
4 amputation, those are done under general  
5 anesthetic?

6 A. Yes, sir.

7 Q. Were there any complications from that  
8 appointment or from that procedure?

9 A. No, nothing unusual.

10 Q. Did Tina continue to follow up with you both as  
11 an in-patient at Hamot and here in your office?

12 A. Yes, she did.

13 Q. And during the course of your follow-up  
14 treatment did she develop additional problems  
15 that required yet another surgery?

16 A. Yes, she did.

17 Q. Can you tell me when it was that you were  
18 forced to perform your third surgery on Tina  
19 Lindquist?

20 A. All right.

21 Q. And I believe that's the osteotomy.

22 A. Yeah. That's why I'm -- excuse me for  
23 muttering for myself. I'm sorry. I'm just  
24 trying to read through this. I believe that  
25 would have been 2/17/03.

1 Q. What type of operation did you perform that  
2 day, doctor?

3 A. Um, let's see here. I have a physical exam.  
4 Hold on. I need to go to the op report. We  
5 did a osteotomy with plating of the left long  
6 and ring finger and removal of the left great  
7 toe nail.

8 Q. Can you tell us what an osteotomy is?

9 A. It's where the bones are cut and cleaned out at  
10 the end. So it's like, um, what we basically  
11 did there is like what they do with grapevines  
12 in the United States. You have a root system  
13 that's part of a different plant than the  
14 growing part, the leafy part of the grape, and  
15 you splice it together. Okay. So we're  
16 basically trying to get the two pieces of bone  
17 to grow together to make a solid piece of bone.

18 Q. Is that procedure done under general  
19 anesthetic?

20 A. Yes, it was.

21 Q. Does it require a hospital stay?

22 A. Um, I believe we kept her in over night. I  
23 don't believe that was outpatient.

24 Q. Did Tina continue to follow with you as a  
25 patient after that osteotomy?

1 A. Yes.

2 Q. Was there any complications from that  
3 osteotomy?

4 A. She failed to heal that bone.

5 Q. When you say she failed to heal, the bones  
6 failed to join together?

7 A. Yes.

8 Q. As a result of that was additional treatment  
9 necessary?

10 A. Yes.

11 Q. Can you tell us, doctor, what you had to do  
12 surgically since the osteotomy failed?

13 A. Basically she had broken the plates, which are  
14 those tiny pieces of metal that I put screws  
15 through to hold the bone together. On April  
16 21st of 2003 we, I took down those nonunion  
17 sites, meaning I opened it up, took the scar  
18 tissue out that was between the bones and put  
19 new plates and screws on to them.

20 Q. In that osteotomy, is that when you're actually  
21 putting a small metal plate and screw in her  
22 fingers?

23 A. The osteotomy is technically the cutting of the  
24 bone itself. The plating is the action of  
25 putting the plates and screws on.

1 Q. So that fourth procedure would have been to  
2 take out those plates and screws?

3 A. The initial ones and putting a new set in  
4 because she broke the first ones.

5 Q. Did you continue to follow with Tina as a  
6 patient in your office after that fourth  
7 operation?

8 A. Yes, I did.

9 Q. Did she develop any additional complications?

10 A. Yes. She had problems with infections in the  
11 soft tissues mostly on the left hand.

12 Q. And as a result of that what type of treatment  
13 did you render to help her with those  
14 infections?

15 A. She got antibiotics, a couple courses of I  
16 believe Keflex and some Ciprofloxacin, or Cipro  
17 was the general term for it.

18 Q. Now doctor, at that point in time you had to  
19 remove another digit of Tina's hand, mainly I  
20 think it was the index finger of the right  
21 hand?

22 A. Right hand.

23 Q. Is that correct?

24 A. Yeah.

25 Q. I'm going to show you a series of photographs,

1 doctor, and ask you if those depict Tina's  
2 hands as they would have looked after that  
3 third surgery, the osteotomy?

4 A. Yes, they would. Though, um, they are after  
5 the osteotomy. But these pictures of her left  
6 hand are, this is showing pictures after her  
7 toe to hand transfer. So the right hand would  
8 have looked that way. Oh, sorry.

9 Q. Doctor, while the videographer is panning  
10 through those pictures, were you able to get  
11 the infection that was plaguing Tina after that  
12 fourth surgery under control?

13 A. Yes.

14 Q. And you did that through medication?

15 A. Yes.

16 Q. Did she continue to come to your office for  
17 treatment and various therapies?

18 A. Yes, she did.

19 Q. Was there an occasion that you had to perform  
20 yet a fifth surgery on Tina Lindquist?

21 A. Yes.

22 Q. Can you explain to us, can you explain what  
23 procedure it was that you did?

24 A. Well, there was a couple of things I think  
25 you're getting at. First she came to the

1 office and she was scheduled for what we call a  
2 toe to hand transfer where we take one of the  
3 person's toes and put it on the hand, use it as  
4 a digit.

5 Prior to that she got an infection in  
6 her toenail of the foot that we were going to  
7 use. So I had to take her toenail off again in  
8 the office and then wait for that to clear  
9 before we could schedule her for that surgery  
10 for the toe to hand transfer.

11 Q. Why, or what goes into the process of deciding  
12 that a patient is a candidate for a toe to hand  
13 transfer?

14 A. It comes down to function and what she has as  
15 far as fingers or thumb goes. In this instance  
16 Tina's withered fingers on the left hand really  
17 gave her nothing more than what basically the  
18 palm of your hand would to push against with  
19 her thumb. So she didn't have anything to  
20 pinch against.

21 So the whole idea was to either take  
22 one or two toes to transfer that to the hand to  
23 give her, try to give her a couple of fingers  
24 essentially to pinch off against.

25 Q. So if I understand this correctly, doctor, you



1 surgically removed one of her toes and attached  
2 it to her hand?

3 A. That's correct.

4 Q. With the hopes that the toe will act as a  
5 finger?

6 A. Yes, essentially, yes.

7 Q. And is this a procedure that is common?

8 A. Not common, no. But it's well documented.

9 Q. Now, I'm going to show you a series of  
10 photographs, doctor. You, I think you pointed  
11 out in this last set that there's actually some  
12 pictures here where the toe is attached to her  
13 hand?

14 A. Yes.

15 Q. Can you just identify maybe by number?

16 A. 168, this one here. This one here is that.  
17 This one here is that.

18 Q. That's 168, 170, 175?

19 A. 181, um, and yeah, 173.

20 Q. And in order to do that you have to harvest,  
21 surgically harvest the toe; is that correct?

22 A. That is correct.

23 Q. I'm going to show you a series of photographs,  
24 doctor. And what do those photographs depict  
25 for us?

1 A. It shows her right foot here and here with one  
2 of the toes missing. That's her left foot with  
3 all five toes. And two pictures of her hand  
4 with the toe transposed onto her left hand.

5 Q. So you would surgically cut which toe off of  
6 her foot?

7 A. Traditionally it's the second toe, and that's  
8 what this was.

9 Q. Okay. So you take her second toe, I guess the  
10 toe next to the great toe?

11 A. That's correct.

12 Q. And then you have to do a surgical procedure on  
13 her foot?

14 A. Um-hum.

15 Q. Is that correct?

16 A. That is correct.

17 Q. Does the loss of the toe have any effect on the  
18 foot as far as balance or gate?

19 A. Not a whole lot. Generally that's been found  
20 not to make a big difference after everything's  
21 healed in six months to a year down the road.

22 Q. Okay. But for six months to a year there would  
23 be some issues with balance and gate?

24 A. More soreness and tenderness in the foot.

25 Q. And then you surgically, through the same

1 procedure you sew it on to or attach it to her  
2 hand; is that correct?

3 A. That's correct. We, once again, hook the  
4 nerve, the blood vessels, the tendons and the  
5 bones back together.

6 Q. So during this fifth surgery, the toe to hand  
7 transfer, it's similar to the first surgery.  
8 You have to revascularize -- but it's a cleaner cut  
9 because you do it surgically; is that correct?

10 A. Yeah, that's correct.

11 Q. But you have to revascularize, I think you said you had  
12 to make sure that the nerves, the blood  
13 vessels, the bones, everything's in conformity;  
14 is that right?

15 A. That is correct, sir.

16 Q. Did she tolerate that toe to hand transplant?

17 A. Yes, she did.

18 Q. Does she now have that toe affixed to her hand?

19 A. Yes, she does.

20 Q. And you did that based upon the fact that she  
21 would have no function in her hand without  
22 that?

23 A. She would have been much more limited, yes.

24 Q. After the toe to hand transfer did you  
25 discharge Tina and send her on her way, or did

1 she need additional care?

2 A. She needed additional care. As a matter of  
3 fact, the day of that transplantation I had to  
4 come back in the middle of the night to redo a  
5 blood vessel because the toe became blue and  
6 very cool, which means that blood's getting  
7 into it but it's not flowing out. So it  
8 becomes congested. So I had to redo one of the  
9 vascular repairs that evening.

10 Q. Okay. So on a toe to hand surgery there was a  
11 risk, for lack of a better word, that it was  
12 being rejected?

13 A. Um-hum. Just lost. I wouldn't say rejection.  
14 Rejection denotes that it's not part of  
15 herself. But yeah, it could have lost it's  
16 blood supply and died.

17 Q. And during that emergency surgery on October, I  
18 guess that'd be the 9th of 2003, did you  
19 successfully revascularize that toe?

20 A. Yes.

21 Q. Does it remain attached to her hand to this  
22 day?

23 A. Yes, it does.

24 Q. Did she develop additional problems that  
25 required treatment?